



USAID
FROM THE AMERICAN PEOPLE

CENTRAL ASIAN REPUBLICS

TECHNICAL REPORT: MEDICATION-ASSISTED TREATMENT IN KAZAKHSTAN, KYRGYZSTAN AND TAJIKISTAN

July 2011

This publication was produced for review by the United States Agency for International Development. It was prepared by Ingrid van Beek, Paul Williamson, Dave Burrows and Danielle Parsons for the Quality Health Care Project in the Central Asian Republics.

The USAID Quality Health Care Project is a five-year program designed to improve the health of Central Asians by strengthening health care systems and services, particularly in the areas of HIV/AIDS and TB care and prevention. The project assists governments and communities to more effectively meet the needs of vulnerable populations, with the aim of increasing utilization of health services and improving health outcomes. The Quality Health Care Project is part of USAID's third objective of investing in people as part of the US Strategic Framework for Foreign Assistance.

Recommended Citation: van Beek, I, Williamson, P, Parsons, D, and Burrows D. July 2011. *Medication-assisted treatment in Kazakhstan, Kyrgyzstan and Tajikistan*. Bethesda, MD. Quality Health Care Project in the Central Asian Republics, Abt Associates Inc.

Contract No.: AID-176-C-10-00002

Submitted to: Bryn Sakagawa
Deputy Director, Office of Health and Education
USAID Central Asia Regional Mission

TECHNICAL REPORT: MEDICATION-ASSISTED TREATMENT IN KAZAKHSTAN, KYRGYZSTAN AND TAJIKISTAN

DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development (USAID) or the United States Government

CONTENTS

Acronyms vi

Executive Summaryvii

I. THE PROJECT I

1.1 Project Aims 1

1.2 CONSULTANTS..... 1

2. INTRODUCTION..... 3

2.1 MAT in Tajikistan 3

2.2 Mat in Kyrgyzstan 3

2.3 Mat in Kazakhstan 4

2.4 Purpose of MAT Dialogues 4

Site Visits and MAT Dialogues..... 5

3. 5

3.1 Tajikistan 5

3.1.1 Site Visit 6

3.1.2 MAT Dialogue 7

3.1.3 Specific Recommendations..... 8

3.2 Kyrgyzstan 8

3.2.1 Site Visits 8

3.2.2 MAT Dialogue 9

3.2.3 Specific Recommendations..... 10

3.3 Kazakhstan 10

3.3.1 MAT Dialogue 10

3.3.2 Specific Recommendations..... 13

4. General recommendations 15

4.1 Overcome barriers to raising MAT clinic numbers 15

4.2 Ensure existing pilot MAT sites are 'low threshold' 15

4.3 Ensure MAT is accessible and acceptable to IDUs..... 16

4.4 Maximize client retention to achieve MAT goals 16

5. Next steps..... iii

Annex A: Presentation by Australian consultants iv

Annex B: Clinician Site Reports.....viii

Annex C: Bibliography x

ACRONYMS

Ab	Antibody
AIDS	Acquired Immune Deficiency Syndrome
AM	Member of the Order of Australia
ART	Antiretroviral Treatment
BBI	Blood-Borne Infection
FACHAM	Fellow of the Australasian Chapter of Addiction Medicine
FAFPHM	Fellow of the Australian Faculty of Public Health Medicine
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HR	Harm Reduction
IDU	Injecting Drug User
MAT	Medication-Assisted Treatment
MHSM	Master of Health Services Management
NGO	Non-Governmental Organizations
NSP	Needle and Syringe Program
PHC	Primary Health Care
STI	Sexually-Transmitted Infections
TB	Tuberculosis
UNAIDS	Joint United Nations Program on HIV/AIDS
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

EXECUTIVE SUMMARY

In the Central Asian region, HIV infection, mostly attributable to the injection of illicit opioids (mainly heroin) and more recently an upsurge in sexual transmission among partners of injecting drug users, is reaching endemic levels.

In 2009, the WHO endorsed Medication-Assisted Treatment as an effective means of combating the combined threats posed by HIV and opioid dependence and has recommended that at least 40 per cent of opioid dependent IDUs should receive MAT using methadone or buprenorphine. [1]

The consultant team visited Tajikistan, Kyrgyzstan and Kazakhstan to visit MAT sites and participate in dialogues with clinicians, NGOs and international aid partner representatives.

Kyrgyzstan introduced MAT in 2002 and now has 20 treatment centers in various settings including penitentiary facilities. Kazakhstan and Tajikistan introduced MAT later, each having only two or three pilot sites currently providing such treatment, which only commenced operating over the past year or so.

The longer experience in Kyrgyzstan was reflected in a greater number of treatment sites, greater numbers of patients and greater decentralization with clinics also situated in family medicine centers, and not just specialist narcology centers. Its clinics seemed to have the most welcoming environment in the region, with effective linkage to a comprehensive needle-and-syringe program.

MAT in Tajikistan and Kazakhstan appeared to have a more rigid and centralized approach, perhaps related to being at an earlier stage of evolution.

The number of people receiving MAT is inadequate by any standard in all three countries. Kazakhstan, for example, has only around 120 patients receiving methadone among its estimated 100,000-160,000 IDU population.

An urgent need exists in the countries for a massive scale-up of MAT availability and clinics need to examine their service-delivery models. These models should seek to achieve a balance between a public health approach, which would maximize IDU population coverage, and a clinical approach, which would ensure individual patients had access to high-quality holistic care.

The MAT programs have tenuous political support and their “pilot-program” status remains indefinite at this stage. Funding is met almost entirely from donor assistance, with little financial commitment from national governments.

Considerable pressure to curtail MAT has been brought to bear by Russia, some members of the medical profession, and other parts of the society.

The consultants identified the following four major areas of recommendations, common among the countries to a greater or lesser degree. The country-specific recommendations appear in the body of this report.

1. OVERCOME BARRIERS TO THE EXPANSION OF MAT CLINICS IN ALL JURISDICTIONS

- Increase acceptance and support of the MAT approach in local communities:
 - Encourage and support MAT advocacy activities led by medical and other professional associations, including the wider dissemination of MAT service evaluation, and review findings in the scientific literature;

- Support the formation of NGOs representing the families and carers of IDUs to advocate MAT's benefits among local and national politicians and other community opinion leaders through various media; and,
- Support the formation of consumer groups to promote the MAT approach among opioid-dependent IDUs, their families and the broader community.
- Deregulate MAT delivery systems:
 - Consider authorizing non-narcologist medical personnel, and mid-level health care workers (nurses, feldshers), at a greater range of sites to prescribe and/or dispense methadone, including HIV and TB specialists, general medical practitioners, HIV and TB treatment and primary-health-care settings and pharmacies;
 - Explore opportunities to initiate or continue MAT inpatient hospital and correctional settings so continuity of treatment is assured;
 - Consider other modes of MAT delivery such as custom-made outreach vehicles to achieve geographical coverage to more remote locations where health personnel is limited. Telemedicine options (for example, using Skype) should also be explored to enable narcologists to give specialist support to remote regions.

2. ENSURE EXISTING PILOT MAT SITES ARE 'LOW THRESHOLD' - HAVE LOW BARRIERS TO CLIENT ENTRY

- Review client eligibility criteria to ensure they are unrestrictive. For example, remove the need to demonstrate more than one previous failure in drug detoxification programs, to be opioid dependent for more than two years, and/or HIV positive.
- Consider the introduction of funding models based on the average daily number of clients attending, to increase incentive to enroll and retain more IDUs in MAT.

3. ENSURE MAT IS ACCESSIBLE AND ACCEPTABLE TO IDUS

- Decentralize locations of MAT clinics to be near where IDUs reside to avoid travelling time, associated costs and client congregation;
- Ensure clinics have a welcoming atmosphere; review the need for high-security arrangements;
- Review operating hours of MAT clinics; encourage extended hours into mornings and evenings to maximize client treatment coverage capacity, enable client employment and split-dosing arrangements;
- "De-medicalize" MAT delivery models: Refocus specialist narcologists' efforts on: clients with more complex medical treatment needs, MAT induction, and early stabilization. Less complicated cases should be referred to other health practitioners once stabilized. Narcologists should also be resourced to provide continuing training and support in "shared-care" arrangements to such practitioners where appropriate.
- Support the development of more extended nursing roles to include counseling and welfare-support capacity;
- Develop the nurse practitioner role, particularly for remote regions that lack medical staff;
- Support training and employment of additional personnel with psychosocial and welfare

assistance skills to assume case management responsibilities in MAT clinics.

- Encourage client participation and feedback in MAT planning and delivery.

4. MAXIMIZE CLIENT RETENTION TO ACHIEVE MAT GOALS

- Support the development of the “client management” approach, particularly in a client’s early treatment phase and for those with more complex health and psychosocial needs.
- Encourage the collocation and integration of other relevant health and social welfare services with MAT including ART, TB, HBV and HCV therapies; needle and syringe programs; mental, sexual, reproductive, child, maternal, and antenatal health; dental; general health; counseling; social welfare services, and drop-in areas.
- Ensure the continuity of MAT by developing systems to enable the temporary transfer of clients’ methadone dispensing to hospital and correctional settings.
- Explore the significant challenge to continuity of care posed by high migration levels to other areas and countries in the region, particularly from Tajikistan to Russia or places of high HIV prevalence among IDUs.
- Conduct “assertive follow-up” surveys of those patients who leave MAT to determine why they discontinued methadone.

1. THE PROJECT

The Quality Health Care Project invited two senior Australian addiction medicine specialists to travel to Kazakhstan, Kyrgyzstan, and Tajikistan to meet the heads of Narcology Services, conduct site visits of narcology clinics providing Medication-Assisted Treatment (MAT), and participate in “MAT dialogues” with clinical staff and representatives of non-governmental organizations (NGOs), UN and other aid partners concerned with HIV and injecting drug use in the respective countries.

1.1 PROJECT AIMS

- Discuss practical operational aspects of methadone treatment in Australia and to understand the approaches taken in the Central Asian countries;
- Examine the extent of integration with other related services, particularly those involving HIV, tuberculosis and hepatitis C treatment;
- Review barriers to the scale-up of MAT and, where possible, suggest measures to overcome such barriers; and,
- Review client-perceived barriers to treatment, particularly those related to admission and retention.

1.2 CONSULTANTS

Dr. Ingrid van Beek AM – MBBS MBA FAFPHM FACHAM MD

Dr. Van Beek is a public health and addiction medicine physician with post-graduate qualifications and extensive experience in health-service management and clinical-service provision. She is also a Doctor of Medicine (MD) in recognition of her significant body of published work in the international field of harm reduction.

Since 1989, she has been the director of the Kirketon Road Center (KRC), a primary health care (PHC) service for at-risk young people, sex workers and people who inject drugs, located in Sydney’s Kings Cross – an epicenter of illicit drug use and the sex industry in Australia. KRC has integrated STI case management, low-threshold methadone treatment access, ART, outreach, and NSPs into its service model, which has been recognized as a “best-practice” model by the WHO.

Dr. Van Beek has been a consultant advising on approaches to HIV and STI among commercial sex workers and people who inject drugs in resource-poor settings since 1997, undertaking missions in Indonesia, the Philippines, Malaysia, China and Laos. She also wrote the chapter on Injecting Drug Users in the WHO’s first edition of *Scaling up anti-retroviral therapy in resource-limited settings: Guidelines for a public health approach*. [Geneva: 2002] and was a foundation member of the United Nations Reference Group on HIV/AIDS Prevention and Care among IDU in Developing and Transitional Countries, under the auspices of the WHO, UNODC and UNAIDS from 2002 - 2007.

Dr. Paul Williamson – MBBS FACHAM MHSM

Dr. Williamson is an addiction medicine physician, having become a Fellow of the Australasian Chapter of Addiction Medicine in 2002. He also holds a Master of Health Services Management degree. He has 29 years of direct clinical experience in addiction medicine, and is employed by

Drug and Alcohol Services department of the state of South Australia as the manager of the largest opioid maintenance pharmacotherapy clinic in the state, with more than 600 patients.

He has also played a crucial role in the expansion of opioid maintenance treatment in the state through his involvement in training private general practitioners and private community pharmacists. He has also conducted research into methadone-related overdose deaths, buprenorphine implants, and buprenorphine film technology.

In 2007, the WHO commissioned him to assess heroin use and the need for opioid maintenance treatment in Lebanon. He has also been a consultant to the Northern Territory's Alcohol and Other Drugs Program of the since 1997.

2. INTRODUCTION

Central Asian countries are facing an already serious and growing HIV epidemic, particularly among people who inject drugs. HIV infection rates among IDUs have been recently estimated at around 9-10 percent in Kazakhstan and 7-8 percent in Kyrgyzstan. In a sentinel surveillance study in Tajikistan in 2008, 17.6 percent of IDUs were found to have HIV infections. There is also evidence of an increasing rate of sexual transmission of HIV among IDUs' partners in these countries.

Other transmissible infections are also prevalent including hepatitis C, tuberculosis and syphilis. Sentinel surveillance revealed that 48 percent of IDUs had been exposed to HCV in Kyrgyzstan in 2006 and 30 percent in Tajikistan in 2008.

The major illicit drug injected by IDUs in this region is heroin, as supply routes for northern Europe and Russia traverse these countries. The supply is apparently plentiful, the quality is high and the price is low compared those of places further downstream from the source country, Afghanistan. The estimated numbers of heroin injectors range from 100,000-160,000 in Kazakhstan, 20,000-55,000 in Tajikistan and up to 25,000 in Kyrgyzstan. These IDU population estimates were for the period 2002-2008 and may underestimate the actual numbers of IDUs today.

MAT programs have been shown to reduce the transmission of HIV in European countries and in Australia [Farrell et al 2005], particularly in conjunction with comprehensive NSPs. In 2009, the WHO recommended a "low-threshold" approach to MAT – programs with low barriers to entry – because only the wide implementation of such treatment would be effective in slowing the transmission of blood-borne infections. In 2009, the WHO, UNAIDS and UNODC jointly recommended that the uptake of MAT needs to be at least 40 percent among the IDU population to have an effective impact in this regard.

2.1 MAT IN TAJIKISTAN

MAT has only been available in Tajikistan since last year and the pilot program was initially expected to treat 200 patients, rising to 700 by 2014. At present, two programs are operating, with a third due to start, but currently delayed. Only around 100 people are currently in MAT at present. MAT is funded by the GFATM with the primary aim of reducing the transmission of HIV among people who inject drugs. Control of MAT is shared across several ministries, potentially leading to a fragmented approach with significant duplication of resources. Legislation is lacking with regard to direct support of MAT through law.

MAT must be carried out by narcologists in specialist clinics, patients are forbidden to hold driver's licenses while receiving MAT, and treatment ceases if patients are jailed or relocate from their region. Dosing conditions such as hours for dispensing, convenient locations, and the like are restrictive.

2.2 MAT IN KYRGYZSTAN

MAT commenced in 2002 and the number of methadone-prescribing sites has grown to 20, with three within the prison system. MAT is supported by government decree; however, the threshold for treatment remains quite high. It is carried out at special treatment facilities or by narcologists at Family Medical Centers (FMCs). Evaluation has been performed showing effectiveness in reducing drug use and risky injecting behavior and improved physical health and social functioning.

Support for MAT has remained reasonably strong at a political and social level, despite influence from Russian media and officials. A number of NGOs have taken a strong role in MAT advocacy, particularly since concerted efforts were made in 2009 to discredit MAT.

The government is yet to make a financial commitment to MAT so the programs are reliant on aid money.

2.3 MAT IN KAZAKHSTAN

A pilot MAT program commenced with two sites at Pavlodar and Karaganda in 2008. A third site commenced in East Kazakhstan province last year. These sites have small numbers in treatment with a maximum capacity of 50 clients at each site.

Control of MAT programs is fragmented across several government departments, the legal framework for methadone treatment is not well-established and the promotion of MAT by government agencies, NGOs and health professionals is inadequate, particularly in the face of rising Russian opposition to MAT. The threshold for entry into treatment is higher than that recommended by the WHO and accessibility of treatment is limited because patients cannot travel to other regions and continue treatment. Other continuity problems include lack of availability of MAT in prison and general hospital settings.

2.4 PURPOSE OF MAT DIALOGUES

All three countries have now established at least fledgling MAT programs and have undertaken a great deal of training efforts. The USAID Quality Health Care Project, and its subcontractor, APMG, were keen to move from a pedagogic approach to a less-formal training format in which discussion could be more easily stimulated and approaches to practical issues discussed in a friendly, open atmosphere with good learning outcomes for both the Central Asian clinicians and administrators, and the Australian addiction medicine specialists.

The six-topic agenda for the MAT dialogues had been discussed and agreed upon before the meetings occurred. The topics were:

- 1) Enrollment,
- 2) Physical aspects of MAT clinics,
- 3) Methadone dose consideration,
- 4) Success and failure,
- 5) Prevention of diversion, and,
- 6) Maximizing treatment adherence.

The consultants' Powerpoint presentations were translated into Russian prior to their arrival in Central Asia (see Annex A). Site visits and meetings with senior government officials with responsibility for MAT were also planned to provide added contextual information before the dialogues took place.

It was hoped that the MAT dialogue format would provide an opportunity for clinicians to confirm that important elements of their MAT programs were operating according to best practice and to reflect on ways to reduce barriers to MAT, and in so doing, increase the scale of MAT programs to meet the growing risk of an HIV epidemic among IDUs. It was also an opportunity to examine how MAT services might be better integrated with HIV, tuberculosis, and hepatitis B and C

services. This format would also provide learning opportunities for the Australian addiction medicine consultants on the geopolitical situation regarding drug trafficking and the challenges of setting up MAT programs in an environment in which cheap, high-grade heroin was readily available.

A further expectation was that NGOs directly involved in advocacy for drug-dependent people would have a voice at the dialogues such that the interests of consumers would be given greater weight.

3. SITE VISITS AND MAT DIALOGUES

3.1 TAJIKISTAN

Meetings were held with the Ministry of Health, development partners, the head narcologist involved in MAT provision and MAT clients at an NGO and the following points were expressed:

- Explicit legislation exists to ensure Harm Reduction efforts are not hampered by local police activity.
- The community is somewhat ambivalent toward HR efforts, but there is no active campaign against HR. However, attendants were aware that neighboring countries are increasingly unsupportive (Kazakhstan in particular), and the deputy prime minister – a cardiologist – apparently recently expressed publicly his lack of support for HR.
- Two pilot sites are now operating: one since mid-2010, the other since early this year. Planning is complete for a third site, but its commencement is apparently being held up by the MoH – perhaps related to recently diminishing support at the political level.
- Tajikistan also has NSPs, which also distribute naloxone to treat opioid overdose, and provides drug rehabilitation in correctional facilities.
- Development partners (the UNODC and George Soros' Open Society Institute Assistance Foundation – Tajikistan) believed there needed to be external motivation for more pilots to be established.
- Concern was expressed by MoH and MAT clinicians about duration of “pilot” programs affecting their sustainability; no specified end of pilot period, or outcome-based key performance indicators attached to this to enable evaluation of pilot MATs.
- Partners and MAT clients expressed concern about the lack of clarity regarding the need to be HIV positive to be enrolled on MAT; recent media were also cited as having publicized this to be a requirement. Concerns were expressed about privacy implications for IDUs seen to be attending MAT. The potential for service stigmatization was also a concern, although there was a general appreciation of the need to prioritize this IDU subpopulation. The potential was discussed for this criterion, if strictly applied, to become an incentive for HIV seroconversion, particularly among those most desperate to deal with their opioid dependence who may not know the full implications of HIV/AIDS. However, clinicians at the MAT dialogue indicated that this was not a strict requirement, citing the fact that only 50 percent of enrollees were HIV positive as evidence for this. MAT clients and their carers consulted were for the most part very enthusiastic about their experience in treatment, and also expressed interest in assuming a greater public advocacy role in this regard. However, there was considerable concern about the limited number of program places and programs available, and how long they would be allowed to remain on these programs given their pilot nature.
- The MAT clients consulted also expressed a need for support while on the program,

suggesting that a drop-in area near the dispensary where structured activities could be conducted would be welcome. Similarly, integrating other relevant services with MAT delivery and a greater emphasis on case management to address underlying psychosocial issues was also sought.

3.1.1 SITE VISIT

3.1.1.1 OPERATING HOURS

The Dushanbe Narcology Center's MAT clinic was closed when we visited; operating hours being restricted to between 8 a.m. and 1 p.m.

3.1.1.2 LOCATION

The clinic is situated on the campus of a Narcology Center in an area near where IDUs live, although many clients need to travel there from elsewhere. The cost of such travel was also raised as an issue given that clients had very limited access to financial support.

3.1.1.3 COMMUNITY ISSUES

Some community concerns had been expressed about more IDUs coming to visit the MAT leading to some congregation in the area, but the lead narcologist apparently liaised with members of the mosque nearby, explaining the clients' situation and need for MAT, and there have been no further complaints since this time.

3.1.1.4 LOCAL EXPERTISE AND CLIENT ATTENDANCE

The narcologist seemed quite familiar with MAT, having also visited drug treatment facilities in Hamburg; although the doctor noted that the situation in Tajikistan was very different. While some 76 clients were currently attending the clinic, there had been a significant number leave, mostly because of the need to migrate to other countries, particularly Russia, to gain work.

3.1.1.5 MIGRATION AND CLIENT DROP-OUT

The need to withdraw such people from MAT before such migration, given that there is no MAT in Russia or transfer arrangements in place in other jurisdictions which do have MAT (such as Kazakhstan and Kyrgyzstan), poses significant clinical challenges, which may even have implications for the appropriateness of commencing such people on MAT in the first place. But of arguably greater public health concern is that apparently a significant number of these clients relapse to injecting opioid use during their time in Russia where HIV prevalence among IDUs is high and access to clean injecting equipment and other means of HIV prevention is low. Many of these subsequently return to Tajikistan having acquired HIV infection in the interim.

3.1.1.6 CLIENT RETENTION

There seemed to be little interest or incentive in maintaining the original number enrolled on MAT, possibly also because of the perceived uncertainty about the program's future.

3.1.1.7 STAFF AND ATMOSPHERE

Other staff introduced, including an "intensive care nurse" involved in dispensing MAT, appeared quite clinical. The actual dispensing area also had a somewhat foreboding appearance, the dispensary itself being behind a large solid steel vault-like door with a small gap through which the methadone is apparently delivered, such that the dispenser would not be able to be seen by the client and vice versa. This door is guarded by a security person during operating hours. Clients' level of intoxication is assessed by a social worker at a desk at the entrance to a rather public anteroom.

3.1.1.8 NSP AVAILABILITY

There was no NSP access on site.

3.1.2 MAT DIALOGUE

3.1.2.1 LOCATION AND ATTENDANCE

Over 30 people including clinicians from the three MAT pilot schemes, MoH and NGO staff attended the MAT dialogue held at the Mercury Hotel.

3.1.2.2 PRESENTATIONS AND DISCUSSION

The respective pilot sites were apparently unable to prepare presentations in the [six-topic] “dialogue” format as planned, so instead presented information about their sites’ MAT eligibility assessment, client characteristics, MAT activity data and their general sense of its outcomes to date. To this extent the planned dialogue format was unsuccessful, although these topics in our presentations generated worthwhile discussion and questions, particularly from NGO representatives in relation to the MATs needing a lower threshold.

3.1.2.3 POSITIVE MAT OUTCOMES

Also noteworthy were the positive clinical outcomes for MAT clients reported by the staff of both clinics, there being strong consensus that MAT was an effective intervention to reduce the range of harms associated with opioid dependence.

3.1.2.4 CHALLENGES OVER CLIENT ELIGIBILITY CRITERIA

However, during these discussions it became apparent that the various symptoms and signs used to diagnose opioid dependence, such as “previous attempts at drug detoxification,” were being applied as MAT eligibility criteria; that is, there was a requirement to provide documentation demonstrating that previous admission to a detoxification program had “failed” at least twice. The consultants clarified that while previous attempts at drug treatment may be used among other aspects of a patient’s history to diagnose opioid dependence (an essential criterion for MAT), and that such attempts may also be an indicator that the person is highly motivated to treat their opioid dependence (also important to ascertain as part of assessing the appropriateness of MAT): the lack of such attempts should not be used as an exclusion criterion. This is particularly the case because access to other treatment modalities is very limited, and drug detoxification, which is associated with high rates of relapse, can lead to lifestyle instability that may impair ART adherence among those IDUs with HIV infection.

3.1.2.5 PERCEPTION OF MAT AS A ‘LAST RESORT’

It also became apparent that while the MoH officials and clinicians understood and supported MAT as an HR strategy to prevent HIV transmission, some may have had a very literal interpretation in this regard – seeing MAT as a “last resort” approach when “more legitimate” opioid dependence treatment (drug detoxification) had failed. The consultants also sought to clarify this matter, emphasizing the evidence demonstrating that methadone should in fact be regarded as a first-line demand reduction AND harm reduction approach.

3.1.3 SPECIFIC RECOMMENDATIONS

1. Encourage MAT clinics to maximize the number of clients currently enrolled and maintain the number of clients receiving MAT at any one time at the upper limits of clinics' capacity.
2. Seek clarification on the duration of the two pilots and commencement of the third, and develop a plan to ensure continuing MAT access for current MAT enrollees in the event that support for the three pilots is withdrawn.
3. Conduct focused MAT training for clinicians to ensure an understanding of:
 - i. *The delineation between the symptoms and signs used to diagnose opioid dependence and their application as MAT enrolment criteria;*
 - ii. *An understanding of the need to prioritize HIV-positive IDUs but not exclude high-risk HIV-negative IDUs from MAT;*
 - iii. *The role of MAT compared with other treatments as a first-line approach to the treatment of opioid dependence.*
4. Review security requirements to encourage MAT dispensing to occur in a more open and welcoming environment.
5. Explore opportunities to develop a case manager role at the MAT sites to include counseling and social-welfare assistance.
6. Explore alternative treatment options for the more itinerant IDUs and those MAT clients seeking to migrate elsewhere, including the use of depot naltrexone for relapse prevention.

3.2 KYRGYZSTAN

The consultants met Dr. Ruslan Tokubaev, Director of the Republican Narcology Center in Bishkek, who gave an overview of the MAT program in Kyrgyzstan and indicated good support for this program. Arrangements for MAT delivery appear to be more varied and flexible compared to elsewhere in the region, perhaps indicative of the relative maturity of the country's program, which has been operating for the past nine years.

Apparently at least 20 MAT programs operate throughout the country; MAT and ART is provided from dosing points in close proximity, and there is good collaboration between narcologists who oversee the management of drug dependence and infectious disease physicians who manage HIV/AIDS.

Especially in rural areas, MAT is often integrated in primary health care settings, which usually have a narcologist on staff. But non-narcologists can also oversee MAT in such settings following specific training in Bishkek.

MAT is also available in the correctional setting, in 3 sites.

3.2.1 SITE VISITS

3.2.1.1 OPERATING HOURS

The consultants visited two MAT sites, both of which were operating at the time.

3.2.1.2 SECURITY AND ATMOSPHERE

The first was in the Republican Narcology Center, and the second was collocated in a Family Medical Center (FMC). Both dispensing areas had the required security arrangements in place, but were more welcoming compared with the MAT in Dushanbe, Tajikistan. Particularly the MAT collocated in the FMC had a warm, friendly atmosphere, which seemed to blend in with the various other clinical activities taking place at the FMC.

3.2.1.3 COMMUNITY ISSUES

While this more integrated service arrangement appeared to normalize MAT within the FMC as a medical treatment for a condition like any other, staff did report having occasional issues with local police, clinicians from other FMCs and members of the local community who did not support this approach. MAT clients queuing for methadone in the morning had also led to concerns among the staff of the laboratory immediately adjacent, but these were manageable.

3.2.1.4 NSP AVAILABILITY

There was an NSP in a room across the corridor from the MAT; the consultants met several NSP and outreach workers and their team leader, who seemed to have a very good understanding of harm reduction and the role of NSP in HIV prevention. These staff members were also very supportive of MAT, often referring NSP clients to this and other relevant services.

3.2.2 MAT DIALOGUE

3.2.2.1 LOCATION AND ATTENDANCE

The MAT dialogue took place at a hotel at Lake Issyk-Kul at the end of day one of a larger meeting of government health-care workers, policymakers, development partners and legislators, which culminated in parliamentary hearings about the legal framework governing HIV and illicit drug use on day two.

3.2.2.2 PRESENTATIONS AND DISCUSSION

One of the consultants presented on “Harm Reduction in Australia” in a session titled “International Harm Reduction” as part of the larger meeting.

While the dialogue format appeared to work better on this occasion – the local MAT staff having developed a comprehensive presentation in keeping with the six-topic format – the effectiveness of the session was somewhat limited by this being the last session of the day in what was too large a conference room for the subgroup of the meeting delegates who attended.

3.2.2.3 POSITIVE CLINICAL OUTCOMES

However, discussion among the clinicians was fruitful and it was noted that while the respective sociocultural contexts may have been very different, the similarities were far greater than any differences when it came to the overall approach to MAT and client care generally. Clinicians also reported very positive clinical outcomes among their MAT clients. But a difference noted was the higher proportion of specialist [narcologist] medical staff involved compared to nursing and staff skilled in addressing psychosocial issues.

3.2.2.4 DEAL TO EXTEND MAT SITE OPERATING HOURS

Despite the limited time for fuller discussion, delegates agreed to seek to extend the operating hours of the MAT sites in Kyrgyzstan to include afternoon hours.

3.2.3 SPECIFIC RECOMMENDATIONS

1. Consider supporting the development of the MAT collocated in the FMC to become a demonstration MAT model for the region.
2. Review MAT clinics' hours of operation to maximize coverage during the day.
3. Explore opportunities to extend the nursing role at MAT sites to include case management, counseling and social-welfare assistance – particularly in more remote areas where there are few specialist narcologists. Nurse practitioners may also be able to oversee MAT prescribing under their supervision.

3.3 KAZAKHSTAN

3.3.1 MAT DIALOGUE

Due to time, geographical and political limitations, the consultant team was not able to conduct site visits to MAT sites in Kazakhstan. Therefore, the primary activity in Kazakhstan was the MAT Dialogue.

3.3.1.1 LOCATION AND ATTENDANCE

The MAT Dialogue was held in the Kazakhstani capital of Astana, attended by clinicians from three MAT sites, and representatives from the MoH, UNAIDS, and the UNODC.

3.3.1.2 SUMMARY BY MAT DIALOGUE FACILITATOR

IDU, HIV POSITIVE AND SEXUAL TRANSMISSION DEMOGRAPHICS

- There are 16,412 people in Kazakhstan known to be infected with HIV. They are mainly IDUs, accounting for around 65 percent of cases. Sexual transmission had increased from 9 percent of new cases in 2005 to 37 percent last year. This increase largely occurred in partners of IDUs.
- There were an estimated 118,000 IDUs in Kazakhstan; 34,000 inject on a regular basis.

PILOT MAT SITES AND CLIENT CRITERIA

- Three pilot MAT sites in areas with a high prevalence of HIV or drug dependence were selected in 2006 and commenced in 2008. These sites were to treat 50 patients each, with the criteria for treatment selection being:
 - Age 18 or more;
 - Citizen of Kazakhstan;
 - Confirmed diagnosis of opioid dependence;
 - Informed consent to voluntary treatment and HIV testing;
 - Two to three unsuccessful attempts at opioid withdrawal;

FUNDING FOR STAFF

- GFATM provided funding for a multidisciplinary team (narcologist, nursing staff, social worker, and psychologist) at each site.

EXPANSION PLANS

- Plans exist for each site's capacity to expand from 50 to 200 patients and for two more pilot MAT sites to commence. According to the plan, there should have been around 1,000 patients by this year and nearly 3,000 by 2015. However, progress has not been achieved, apparently because of opposition at a number of levels, including public opinion.

CURRENT MAT SITE CLIENT DEMOGRAPHIC

- There are 102 patients receiving MAT at the pilot MAT sites. Of these, 43% are people living with HIV, and 22% are receiving ART.

REPORTED POSITIVE OUTCOMES FROM MAT INCLUDED:

- Stabilized daily life and other medical conditions;
- Decreased illegal drug use evident within three months;
- Decreased criminal activity;
- Decreased HCV transmission and overdose mortality;
- Decreased referrals to hospital accident and emergency departments;
- Improved adherence to HIV and TB treatments;
- Pregnant IDUs had shown improvement in outcomes with fewer children abandoned;
- 96 percent of patients reported improved family relationships;
- 24 percent were employed;
- 100 percent reported a positive dynamic arising from treatment.

DIFFICULTIES PRESENTED BY MAT INCLUDED:

- Rules surrounding the storage of methadone meant that it could not be supplied if patients were admitted to hospital for treatment or were imprisoned, greatly affecting continuity.
- Methadone was wholly imported and was quite expensive. Plans exist to manufacture it locally, which the government could afford to fund, but this cannot proceed until patient numbers increase. Gaps in supply had occurred.
- Limited availability and accessibility of MAT, particularly the added cost for those who had to travel longer distances and problems posed for those who also wished to work elsewhere.
- Medical and nursing opinion was not solidly in support of MAT; there had also been media campaigns against MAT critical that methadone was "just another drug". The pilot nature of the programs also fuelled perceptions that "the medical system is experimenting on us". Health professionals had low awareness of methadone and were often unable to counter negative views.
- There was poor integration with other relevant health and welfare services.

SUMMARY OF NEEDS FOR MAT IN KAZAKHSTAN:

- Legal registration of methadone/buprenorphine so that MAT is not seen as a "pilot" program;
- Greater support from media and politicians;
- Improved infrastructure for provision of MAT services;

- More trained staff to work in MAT to overcome the high turnover of staff in the clinics; and,
- Improved storage and distribution of methadone to prevent gaps in supply.

For further information presented on the MAT sites in Kazakhstan, please refer to Annex B.

3.3.1.3 DISCUSSION

Ensuing discussion encompassed implications of MAT in obstetric and neonatal care; the integration of services; the role of specialist narcologists within a massive scale-up of MAT; the roles of multidisciplinary teams; the numbers of patients that could be managed with current resources; terminology used to describe MAT and how to counter negative perceptions surrounding it.

3.3.1.4 INCREASE IN CLIENT NUMBERS URGED

The current MAT programs seem medical-resource-rich given the relatively low numbers of patients. While the current pilot status of treatment is acknowledged, it should be possible for the clinics to offer treatment to a greater number of patients, given available resources.

3.3.1.5 CAUSE AND DANGERS OF FEW CLIENTS

The decision by the Pavlodar clinic to limit its services to those patients who suffer both opioid dependence and HIV infection has resulted in a low total number of patients in treatment. The consultant team is concerned that low numbers of clients may make it easier for the government to discontinue MAT support, compared to the impact of a clinic able to show high levels of patient-related activity.

3.3.1.6 REFOCUS NARCOLOGISTS' ROLE

The role of narcologists in MAT could benefit from refocusing. At present, only narcologists prescribe MAT to patients in Kazakhstan and a doctor has to be present when MAT is dispensed. A scale-up to 15,000-20,000 patients to meet WHO guidelines will likely exceed available narcology resources. To meet this demand, it will be necessary for narcologists to apply their specialist medical skills to the more complex drug dependent patients while less complex patients are managed by general practitioners, doctors in HIV or TB clinics and other health practitioners.

3.3.1.7 COUNTER MEASURES FOR ANTI-MAT CAMPAIGN

Participants expressed concern that the concerted campaign against MAT in Kazakhstan had resulted in negative perceptions of MAT by members of health professions, the general public, the families of drug users and some drug users themselves. Measures to counter such influences could include:

- Publication of the good outcomes from local MAT programs (as reported by participants);
- Using the testimony of patients (or their families) who have benefited from MAT to change the negative opinions of government decision makers, health professionals, the general public and people who would benefit from MAT; and,
- Enlisting supportive and enthusiastic health professionals, particularly narcologists, to be opinion leaders in the promotion of MAT as an effective treatment modality.

3.3.1.8 CONTINUITY OF TREATMENT

A theme that emerged strongly during the presentations and discussion centered on the problems in ensuring continuity of treatment for patients. At present, MAT is discontinued when

patients enter hospital for other treatment (for example, for TB, HIV, or surgery), are imprisoned or when they move to regions within Kazakhstan or to neighboring countries. Such disruptions of treatment do not promote recovery from drug dependence and are likely to affect the continuity and effectiveness of ART.

3.3.1.9 CONSULTANTS HAIL DIALOGUE'S SUCCESS

Reflecting on the Kazakhstan MAT Dialogue, the consultant team formed the opinion that this was the most successful of the three dialogues. The room was an appropriate size, the presenters from the pilot sites were prepared well and there was a reasonably wide range of participants representing clinical services, government departments and aid agencies. The discussion was enthusiastic with participants eager to ask questions and express opinions. The provision of lunch immediately following the session gave a further opportunity for participants to discuss issues with the consultants.

3.3.2 SPECIFIC RECOMMENDATIONS

1. Maximize the number of clients receiving MAT while continuing to ascertain the likelihood of continued political support for MAT. Decreased support may affect the MAT pilot clinics' ability to assure continuity of care, and require the development of contingency plans.
2. Develop the specialist role of narcologists further by reserving their skills for the more complex patients and encouraging general practitioners and other doctors to prescribe MAT for the less complex patients.
3. Ensure continuity of treatment when patients are admitted to inpatient settings, correctional settings and when they move to regions in the same country.
4. Explore the feasibility of establishing a system to enable the transfer of MAT care to neighboring countries.
5. Identify and recruit narcologists who support the MAT approach to be opinion leaders in Kazakhstan. This may take the form of articles about clinical experiences with MAT in scientific and grey literature, and in various popular media. Their positive attitudes should also be harnessed in training and mentoring programs for MAT clinicians.

4. GENERAL RECOMMENDATIONS

The following recommendations – on furthering the scale-up of MAT coverage among opioid dependent IDUs to reduce HIV transmission in Central Asia – represent a distillation of information that arose during the MAT Dialogues, with observations from the site visits and discussions with NGOs, MAT patients and regional HIV-prevention staff.

4.1 OVERCOME BARRIERS TO RAISING MAT CLINIC NUMBERS

- 1) Increase acceptance and support of the MAT approach in local communities
 - a. Encourage and support MAT advocacy activities led by medical and other professional associations including the wider dissemination of MAT service evaluation and review findings in the scientific literature.
 - b. Support the formation of NGOs representing the families and carers of IDUs to advocate the benefits of MAT to local and national politicians and other community opinion leaders through various media.
 - c. Support the formation of consumer groups to promote the MAT approach to opioid dependent IDUs, their families and the broader community.
- 2) Deregulate MAT delivery systems
 - a. Consider authorizing non-narcologist medical personnel, mid-level health care workers (nurses, feldshers) and a greater range of sites to prescribe and/or dispense methadone including HIV and TB specialists, general medical practitioners, HIV and TB treatment facilities and primary health care settings and pharmacies;
 - b. Explore opportunities to initiate or continue MAT in inpatient hospital and correctional settings so that continuity of treatment is assured;
 - c. Consider other modes of MAT delivery such as custom-made outreach vehicles to achieve geographical coverage in more remote locations where health personnel are limited. Telemedicine options (for example, using Skype) should also be explored to enable specialist support from narcologists in more remote regions.

4.2 ENSURE EXISTING PILOT MAT SITES ARE 'LOW THRESHOLD'

- 1) Review client eligibility criteria to ensure these are not restrictive, for example, remove the requirements to demonstrate more than one previous failure in drug detoxification programs, to be opioid dependent for more than two years and/or to be HIV positive. Training for medical staff potentially involved in client assessment for MAT should incorporate the need to:
 - a. Distinguish between diagnostic indicators of opioid dependence (such as previous attempts at detox) and MAT eligibility criteria, which should minimize barriers to entry. Need to recognize MAT should be considered a first-line rather than last-resort (harm reduction-HIV-prevention strategy only) treatment approach to opioid dependence;
 - b. Distinguish between prioritizing HIV-positive IDUs and excluding HIV-negative IDUs from MAT, particularly as such a requirement potentially stigmatizes MAT programs and also has client privacy implications. It may even become an incentive for HIV seroconversion among IDUs desperate to gain access to MAT.

- 2) Consider the introduction of funding models based on the average daily number of clients attending, to increase the incentive to enroll and retain more IDUs in MAT.
- 3) All clinics should be admitting the maximum number of patients to MAT so that the treatment is seen to have a real force and vibrancy behind it. Any reluctance to offer treatment to new patients because of uncertainty about continued support for MAT modality sends a message that clinic staff are not really behind the treatment and weakens the urgency and impact of MAT. Ceasing support for MAT when there are only 20 patients is a lot easier than if there are 150 patients.

4.3 ENSURE MAT IS ACCESSIBLE AND ACCEPTABLE TO IDUs

- 1) Decentralize locations of MAT clinics to be near where IDUs reside to avoid traveling time, associated costs and client congregation.
- 2) Ensure clinics have welcoming atmosphere; review the need for high security arrangements.
- 3) Review operating hours of MAT clinics; encourage extended hours into morning and evening to maximize client treatment capacity, enable client employment and split dosing arrangements.
- 4) “De-medicalize” MAT delivery models.
 - a. Refocus specialist narcologists’ efforts on clients with more complex medical treatment needs, and MAT induction and early stabilization. Less complicated cases should be referred to the care of other health practitioners once stabilized. Narcologists should also be resourced to provide continuing training and support in “shared-care” arrangements to such practitioners where appropriate;
 - b. Support the development of more extended nursing roles to include counseling and welfare support capacity;
 - c. Develop the nurse practitioner role, particularly for remote regions with a lack of medical staff;
 - d. Support training and employment of more personnel with psychosocial and welfare assistance skills to assume case management responsibilities in MAT clinics.
 - e. Ensure broader access to training for health professionals by ensuring the distribution of written summaries of training initiatives or by using technology to video training sessions and upload them to YouTube, or the like to enable clinicians across the region to benefit.
- 5) Encourage client participation and feedback in MAT planning and delivery.

4.4 MAXIMIZE CLIENT RETENTION TO ACHIEVE MAT GOALS

- 1) Support the development of the “client-management” approach, particularly in the clients’ early treatment phase and for those with more complex health and psychosocial needs.
- 2) Encourage the collocation and integration of other relevant health and social welfare services with MAT, including ART, TB, HBV and HCV patients; needle and syringe programs; mental health; sexual and reproductive health; child and maternal, antenatal, and dental health; general health; counseling, social welfare services; and, drop-in areas.

- 3) Ensure the continuity of MAT by developing systems to enable the temporary transfer of clients' methadone dispensing to hospital and correctional settings.
- 4) Explore the significant challenge to continuity of care posed by high levels of migration to other areas and countries in the region (particularly from Tajikistan to Russia or other places of high HIV prevalence among IDUs).
- 5) Conduct "assertive follow-up" surveys of those patients who leave MAT to determine why they discontinued methadone.

5. NEXT STEPS

The Quality Health Care Project is building on the work carried out by Drs van Beek and Williamson by addressing the barriers that currently exist to expansion of MAT programs in Central Asia. Working with MAT programs of UNODC and the European Union, the Quality Project is supporting MAT advocacy groups in Kyrgyzstan, Tajikistan and Kazakhstan to provide Russian and national-language advocacy materials to counter the misinformation about methadone (in particular) circulating in Russian-speaking countries. Support for these advocacy groups is intended to continue in Year 2.

Given the success of the initial MAT Dialogues, further meetings will be planned for Year 2, focusing on specific operational aspects of MAT.

ANNEX A: PRESENTATION BY AUSTRALIAN CONSULTANTS

ENROLMENT

- Why “low-threshold” methadone treatment?
 - The most socially marginalized people who inject drugs (PWID) are the most at risk of contracting HIV and other blood-borne infections (BBIs)
This group is often the least able to gain access to methadone treatment due to having more “chaotic” lifestyles
 - This group should be prioritized from a BBI prevention and treatment perspective.
 - Pregnant women are another priority population.
- The emphasis should be on achieving lifestyle stability versus being “drug-free” per se
- The main aim is to achieve regular attendance and treatment retention
- The need to reach therapeutic dose (60-80mg) should be proactively promoted among clients

PHYSICAL ASPECTS OF MAT CLINICS

- Opportunities offered by daily clinic attendance
- Regular health reviews
- Monitoring and/or treatment of complex/chronic health issues
- Dosing and monitoring of other medications, for example, HIV, TB, psychiatric medications
- Reproductive health information/provision, for example Pap smears, contraception, pregnancy/antenatal support

To “Normalize” methadone treatment and minimize any “public nuisance” impacts:

- Site clinics in community locations where PWID already reside to minimize need for travel
- Consider smaller programs integrated in primary health care settings to enable a more personally tailored approach
- Collocate and integrate other relevant services where possible so other health and psychosocial issues can also be addressed, especially for complex/high-needs groups
- Minimize physical security barriers (within safety requirements) to minimize any “us” versus “them” (who “can’t be trusted”) atmosphere and maximize client rapport
- Encourage client ownership of the program; ensure clients understand and agree to the conduct expected up front, and consequences for non-compliance
- Train ALL frontline staff in crisis counseling, aggression and critical-incident management
- Be proactive in debriefing staff post-incident and managing stress and “burn-out”

METHADONE DOSE CONSIDERATIONS

- Start safely: 20-30mg

- Increase 0-10mg per day during first week to a dose of 45-50mg
- Increase 10mg per week until adequate dose is reached
- Adequate dose is more than the minimum dose required to control withdrawal symptoms but less than the dose that causes intoxication
- Adequate dose associated with much better treatment retention
- A 35 percent drop-out rate after one month in Australian programs with an average dose of 29mg in late 1980s
- Dose 60-80mg reduce dropout in first 120 days by 50-75 percent

Studies show that:

- A dose of >60mg produces very significant reductions in drug injection
- <10 percent of Australian patients require a dose above 120mg daily
- Doses still need to be determined individually as not all patients require a dose of at least 60mg

Higher doses are associated with:

- Older patients with longer, more severe injecting history
- Patients who are more distressed, anxious
- Atypical methadone metabolism – either naturally occurring or caused by metabolism-inducing drugs, for example Phenytoin sodium, some HIV drugs
- Plasma levels: a trough level of >200 nanograms (ng) per milliliter (ml) generally indicates an adequate dose.
- Withdrawal symptoms are likely to occur if trough level is <50ng/ml
- Divided doses may provide greater comfort for patients with rapid metabolism

FLEXIBLE DOSING

- Adopt a flexible dosing protocol within national guidelines enabling clients to increase or decrease their own dose within a safe range
- Encourage extended dosing hours to enable employment or other activities
- Intercurrent drug use should be assumed, so there is no need for drug testing; but clients need to be assessed clinically for signs of intoxication by a qualified health professional at each visit and not receive their usual dose if intoxicated
- Split or delayed dosing later that day can also be considered to avoid missed doses and the consequent need to decrease the amount below the therapeutic dose, affecting retention
- Ideally a prescriber should be on-call at weekends to assess dose for those who have not attended for several days
- Encourage an “open-door policy”: do not “exit” clients until it is ascertained by their case manager that they no longer wish to remain in treatment

SUCCESS AND FAILURE

- Using urine drug screens for monitoring illicit drug use is, at best, unreliable

- Little evidence that urine drug testing “controls” illicit drug use
- Punishment leads to high drop-out rates
- Some evidence that reward for clean urines is effective
- Urine testing is costly
- Self-reporting does not differ significantly from urine test results
- Supervised testing is humiliating for patients and staff
- Urine drug testing can confirm compliance with treatment
- Use testing to confirm use of opioids at commencement of treatment, to back-up self-reporting at times of increasing treatment privileges.

TERMINATION AND REINSTATEMENT

- Unsafe drug use – generally polydrug use rather than opioids (benzodiazepines, alcohol)
- Repeated drug diversion
- Irregular attendance for treatment
- Episodes of violence or aggression toward staff (remember interferon treatment can increase irritability)
- How are termination decisions made?
- Are there appeal mechanisms?
- Look at contribution of staff and clinic policies in conflict situations
- Have staff been trained to defuse conflict situations
- Offer quick reinstatement to treatment completers
- Consider the use of a behavior management plan when reinstating patients who were terminated involuntarily

SIGNS OF SUCCESS

- Continuing in treatment
- Compliance with treatment requirements
- Demonstrating self-care
- Decreased injecting and risk behavior
- Decreased use of other drugs
- Work, study, family care
- Staying out of prison
- Methadone can only be helpful when it is being taken
- Post-methadone progress is dependent on other factors

PREVENTING DIVERSION

- Double dipping and diversion

Authority to prescribe methadone requires:

- Patient details and photograph on an authority application form faxed by doctor to State Health Department
- An authority number is issued – this must be written on each prescription
- The Health Department keeps the registration details – this information is confidential and is not passed on to other agencies
- All S8 (dangerous drugs) prescriptions are checked against the authorities issued
- Doctors are contacted if opioid prescriptions for patients are detected from other sources
- A termination form is sent to the Health Department upon treatment cessation

At a local level:

- Patient's photograph is attached to the dose-administration sheet
- Patient signs for the dose, including the date and time
- Some difficulties experienced with identical twins and siblings of similar appearance
- Diversion may be for self-injection or supply to others (for example, because of duress or to sell for personal gain)
- High rates of methadone diversion may cause overdose in opioid-naïve persons and damage treatment reputation
- Supervised dosing associated with less diversion and mortality; Each dose supplemented with water to increase volume, patient talks to staff after ingestion
- Take-home dose provisions for patients who have demonstrated stability

MAXIMIZING ADHERENCE - BEYOND THE DRUG ITSELF

- An “intensive case-management approach” is recommended to achieve treatment goals
- Involves articulating these goals in consultation with the client at the outset
- These goals need to be realistic and achievable, reviewing and adjusting these over time as required to ensure they remain relevant
- Also involves identifying underlying psychosocial issues and addressing these in a comprehensive way

CLIENT-MANAGEMENT DOMAINS

- Accommodation
- Drug and alcohol use and dependence
- Health
- Mental health
- Financial
- Legal
- Family and social
- Children and child protection
- Domestic violence

- Education and training

ANNEX B: CLINICIAN SITE REPORTS

INDIVIDUAL MAT SITE REPORTS – KAZAKHSTAN

These were presented by clinical staff from the three clinics currently in operation.

PAVLODAR

- The current case load is 43 patients of whom 19 are HIV Ab negative. Forty-two patients have been terminated from MAT, mostly because of changes in residence, although five went to jail and two were terminated after program violations. The methadone dose ranges between 10-120mg and there are 31 men and 12 women.
- The clinic initially offered treatment only to people who were HIV-infected but did relax this criterion a little. However, the clinic has attracted criticism for this action following an audit of its program and has ceased to offer treatment to HIV-negative people.
- Twenty-nine patients have become employed and the assistance of NGOs in achieving this outcome was acknowledged. Difficulty accessing dose because of the distance travelled was seen as a barrier to employment.
- The prevalence of hepatitis C is 44 percent and of tuberculosis, 10 percent. Patients treated at the TB hospital lose access to their methadone dose unless they are able to come to the clinic by taxi.
- Dosing hours at the clinic are 8 a.m. to 10 a.m. and 4 p.m. to 7:30 p.m. daily.
- Retention rates were reportedly 68 percent (the time period was not given and the figure seemed high considering the number of terminations).
- A narcologist is available on weekends and psychotherapy is supplied for two sessions a week by staff from the HIV center. Staff turnover was reportedly low and the role of the nurse was reported to be significant in this clinic.
- Police were no longer a problem for patients attending the clinic but there were continuing concerns about the disruptive role of journalists.
- Because of uncertainty over continuing funding, only those patients with HIV and opioid dependence were being accepted into the MAT program.

TEMIRTAU

MAT started at this site in 2008 and patients were initially selected by the state HIV center. There are currently 21 patients in the MAT program. Sixty patients have been enrolled in total but 39 have terminated treatment for various reasons including migration, hospitalization and imprisonment.

The positive outcomes include a 15 percent relapse rate, 47 percent employment, decreased crime and improved social status.

Negative effects include:

- Adverse physical effects such as constipation, weight loss and decreased libido.
- Alcohol abuse was recorded in two patients.
- Difficulties with travel and freedom of transport were reported. Patients are unable to hold a

driver's license while receiving MAT, they are unable to continue treatment if they move to another region for work and daily travel to the clinic can be difficult for some.

EAST KAZAKHSTAN

This center started in November last year and has enrolled 52 people of whom 36 remain in treatment. Twelve patients have HIV and 24 are hepatitis C Ab positive. The average age of patients is 32 and nine patients have been employed during the center's operation, although three left treatment to travel for work. A relatively high termination rate after one month was reported. This was thought to be caused by the methadone dose failing to meet psychoactive-effect expectations of the patients.

A number of candidates for treatment have been unable to access it because of their inability to confirm their past attempts at detoxification.

The influence of local specialist physicians who held strongly negative views toward methadone was reported to be a discouraging factor for other doctors, particularly those who could be expected to be significant generators of referrals to MAT programs.

A narcologist at this center explained over lunch that her work in methadone was part-time as she had other clinical responsibilities with alcohol dependence. However, she professed a great enjoyment of her work with MAT clients and wondered whether she could do this work full-time.

ANNEX C: BIBLIOGRAPHY

- [1] WHO, UNODC, UNAIDS. 2009. *Technical guide for countries to set targets for universal access to HIV prevention, treatment and care for injecting drug users*. Geneva: World Health Organization. Available at:
http://www.who.int/hiv/pub/idu/idu_target_setting_guide.pdf
- [2] Farrell M, Gowing L, Marsden J, Ling W, Ali R. 2005. *Effectiveness of drug dependence treatment in HIV prevention*. Maryland Heights, MO: The International Journal of Drug Policy. Volume 16S, pp67-75.
- [3] Latypov A, Otiashvili D, Aizberg O, Boltaev A. 2010. *Opioid Substitution Therapy in Central Asia: Towards diverse and effective treatment options for drug dependence*. Vilnius, Lithuania. Eurasian Harm Reduction Network. Available at:
http://www.aidsactioneurope.org/uploads/tx_windpublications/1800-0.pdf